



GEORGIA CHILD FATALITY REVIEW

Medical Examiner Report

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Office of Child Fatality Review
Georgia Child Fatality Review Panel
55 Park Place, Suite 410
Atlanta, Georgia 30303
T:404/656-4200; F:404/656-5200

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Instructions:

- A. Receive reports of all deaths of children under the age of 18 that occurred in the county.
- B. Notify chairperson of the Child Fatality Review Committee (CFRC) within 48 hours of death if decedent is a resident of county.
- C. If death meets criteria for review (see Section B), and decedent is resident of county, complete Form 1 in its entirety and forward to the chairperson of the CFRC within 7 days of death.
- D. If death does not meet criteria for review, and decedent is resident of county, complete Sections A, B and J of Form 1 and forward to chairperson of CFRC within 7 days of death.
- E. If decedent is not a resident of county of death, notify the coroner in the county of residence of the death within 48 hours, and forward copy of Form 1 to the coroner in the county of residence within 7 days of the child's death.

A. IDENTIFICATION INFORMATION (Decedent)

Decedent's First Name MI <input type="checkbox"/>			County of Residence		
<input type="text"/>			<input type="text"/>		
Last Name			County of Illness/Injury/Event		
<input type="text"/>			<input type="text"/>		
Street Address			County of Death		
<input type="text"/>			<input type="text"/>		
City		State	Zip		RACE <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> White <input type="radio"/> Black <input type="radio"/> Asian/Pacific Islander <input type="radio"/> American Indian/Alaskan Native <input type="radio"/> Multi-racial <input type="radio"/> Unknown/Other
<input type="text"/>		<input type="text"/>	<input type="text"/>		
Date of Birth (MM/DD/YYYY):		Decedent's SS# (if known):		<input type="radio"/> Yes <input type="radio"/> No	
<input type="text"/>		<input type="text"/>			
Date of Death (MM/DD/YYYY):		Phone Number (if known):			
<input type="text"/>		<input type="text"/>			
Natural Mother's First Name MI <input type="checkbox"/>			Natural Father's First Name MI <input type="checkbox"/>		
<input type="text"/>			<input type="text"/>		
Last Name			Last Name		
<input type="text"/>			<input type="text"/>		
Mother's Date of Birth					
<input type="text"/>					

B. CRITERIA FOR REVIEW

Mark all that apply to this fatality. If one or more indicators are applicable, O.C.G.A 19-15, requires that the death be referred to the Child Fatality Review Committee for review.

Death occurring:

- SIDS
- Any unexpected or unexplained conditions
- Intentional injuries
- Unintentional injuries
- Medical conditions when unattended by a physician unless occurred while the person was a patient of a hospice licensed under Article 9 of Chapter 7 of Title 31)
- Sudden death when child is in apparent good health
- Any suspicious or unusual manner
- When an inmate of a state hospital or a state, county, or city penal institution

Referral to Child Fatality Review Committee

- One or more of the indicators marked above apply in this fatality. Case referred to CFRC for review
- None of the indicators listed apply in this fatality. Case referred to CFRC for information only

Note: If death does not meet criteria for review, list cause of death and a brief description of circumstances:



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C. SOCIAL INFORMATION

For all persons living in the residence of the decedent, indicate their relationship, age, and who is the head of household. (Select only one head of household).

Relationship	AGE	Head of Household
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- | | |
|-------------------|-----------------------------|
| a. Natural Father | h. Foster Mother |
| b. Natural Mother | i. Other Relative |
| c. Grandfather | j. Parent's Male Paramour |
| d. Grandmother | k. Parent's Female Paramour |
| e. Stepfather | l. Other non-relative |
| f. Stepmother | m. Sibling |
| g. Foster Father | n. More than two children |

Current marital status of head of household?

- Married Widowed Divorced Never married Unknown

History of domestic violence in home of caretaker(s)?

- Yes No Unknown If YES, by whom? _____

Are other children in family deceased? If YES, Cause of Death? _____

- Yes No Unknown If YES, age at time of death?

D. SUPERVISION

Who was in charge of watching the decedent at the time of injury/illness incident? Check all that apply.

Relationship	AGE
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

- In Charge of Watching Decedent**
- | | |
|-----------------------------|--|
| a. Natural Father | i. Licensed Babysitter/Child Care Worker |
| b. Natural Mother | m. Unlicensed Babysitter/Child Care Worker |
| c. Grandfather | n. Child |
| d. Grandmother | o. Hospital Staff |
| e. Stepfather | p. Other non-relative |
| f. Stepmother | q. No one in charge of watching |
| g. Foster Father | r. Due to decedent's age, no one in charge |
| h. Foster Mother | s. Adoptive Father |
| i. Other Adult Relative | t. Adoptive Mother |
| j. Parent's Male Paramour | u. Other: _____ |
| k. Parent's Female Paramour | |

Was the decedent adequately supervised? Yes No Unknown Not Applicable
 If no, complete questions 1-2.

(1) At the time of the injury/illness event, did the person(s) in charge appear to be:

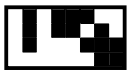
- | | | |
|--|--|-------------------------------|
| <input type="radio"/> Intoxicated | <input type="radio"/> Otherwise impaired (specify) _____ | <input type="radio"/> Asleep |
| <input type="radio"/> Under the influence of drugs | <input type="radio"/> Preoccupied | <input type="radio"/> Absent |
| <input type="radio"/> Mentally ill/limited | <input type="radio"/> Distracted | <input type="radio"/> Unknown |

(2) Is the person(s) responsible for supervising other children?

- Yes No Unknown

Was the injury/illness event witnessed by anyone other than person(s) responsible for supervision of decedent?

- Yes No Unknown Not Applicable



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E. INJURY/ILLNESS SCENE INFORMATION

Place of injury/illness event that resulted in death

- Decedent's home Parking Lot Licensed child care facility Work place
- Other home Street Unlicensed child care facility Rural Road
- Hospital Driveway Child care residential facility School
- Highway Wooded area Body of water Other _____

Date of Injury/Illness Event <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Date Notified <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Time of Injury/Illness Event <input type="text"/> : <input type="text"/> (hour:minute) <input type="radio"/> AM <input type="radio"/> PM	Time Notified <input type="text"/> : <input type="text"/> (hour:minute) <input type="radio"/> AM <input type="radio"/> PM

Notified by

Name	Position	Agency
Arrival Time <input type="text"/> : <input type="text"/> (hour:minute) <input type="radio"/> AM <input type="radio"/> PM		
Time Pronounced Dead <input type="radio"/> Non-applicable Y <input type="radio"/> <input type="text"/> : <input type="text"/> (hour:minute) Was body found? N <input type="radio"/> If Yes, by whom? _____		
Date Found <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Time Found <input type="text"/> : <input type="text"/> (hour:minute) <input type="radio"/> AM <input type="radio"/> FM <input type="radio"/> Unknown		
Had body been moved from place of death? Y <input type="radio"/> N <input type="radio"/> If Yes, by whom? _____		

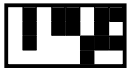
Investigating Officer _____ Position _____ Agency _____

Decedent under care of Physician? Y N If yes, please fill in the Physician's Information below.

Physician's First Name	Physician's Last Name
<input type="text"/>	<input type="text"/>
Physician Address (Street)	
<input type="text"/>	
City	State
<input type="text"/>	<input type="text"/>
Phone #:	Zip Code
<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Medications Prescribed _____	

Decedent transported to _____ Transported by _____

Medical Examiner Notified? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Date <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Time <input type="text"/> : <input type="text"/> <input type="radio"/> AM <input type="radio"/> FM
Autopsy performed? Y <input type="radio"/> N <input type="radio"/>	Blood Alcohol? Y <input type="radio"/> N <input type="radio"/>	Toxicology? Y <input type="radio"/> N <input type="radio"/>



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F. CAUSE OF DEATH

Was death caused by: F1. Injury F2. Illness/SIDs/SUID/Other Natural Causes F3. Unknown

1. Was injury caused by an aggressive or assaultive act?

Yes No Unknown

Was injury:

Intentional Unintentional Unknown

2. Illness or other Natural Cause

Diagnosed Condition _____

Complete questions below if illness or natural cause death in infant <1 year of age

Age at death?

0-24 hours after birth 25 - 48 hours 49 hours - 6 weeks 7 weeks - 6 months 7 months - 1 year

Gestational age at birth?

<25 weeks 26-30 weeks 31-37 weeks >37 weeks Unknown

Multiple Birth: Y N If Yes, #

Birth weight in grams (approximate lbs/oz)?

<750 (<1 lb. 10 oz)
 750 - 1,499(1 lb. 10 oz to 3 lbs. 5 oz)
 1,500 - 2,499(3 lbs. 6 oz to 5 lbs. 5 oz.)
 >2499 (>5 lbs. 5 oz)
 Unknown

Total number of prenatal visits?

None 1-3 4-6 7-10 Unknown

First prenatal visit occurred during?

First Trimester Second Trimester Third Trimester Unknown

Decedent regularly exposed to tobacco smoke

Before birth After birth Both Unknown

Medical complications during pregnancy?

Yes No Unknown

Drug use during pregnancy?

Yes No Unknown

Alcohol use during pregnancy?

Yes No Unknown

History information provided by:

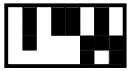
Parent Physician/medical facility Other

3. Unknown Cause (Describe in Section H. Narrative)

G. CIRCUMSTANCES OF DEATH

- Sudden Unexplained Death of Infant or SIDs
- Firearm
- Poisoning Overdose
- Inadequate Care or Neglect
- Asphyxia
- Fire/Burn/Smoke Inhalation
- Vehicular
- Shaken/Impact Syndrome
- Other Inflicted Injury
(Describe in Section H)
- Drowning
- Fall Injury
- Other Circumstances
(Describe in Section H)

H. NARRATIVE



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I. DISPOSITION

Who will sign death certificate?

Body released to

List Personal Belongings

Date [] [] / [] [] / [] [] [] []

Received By

Witness

First Name of Next of Kin

Last Name of next of kin

Street Address

City

State

Zip Code

Phone Number (if known):

J. CORONER/MEDICAL EXAMINER INFORMATION

Coroner's/Medical Examiner's First Name

Coroner's/Medical Examiner's Last Name

If decedent was resident of another county, list name of county and date form forwarded:

County of residence

Date forwarded

Date

Coroner's/Medical Examiner's Signature

Referral for Review Yes No

Date

Child Fatality Review Committee Chair Signature

Accepted for Review Yes No

Date

Date mailed to Office of Child Fatality Review

Date

OCFR Use Only

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